# PHYSICIAN'S NOTICE OF RELEASE TO WORK

***TO BE SUMITTED TO INSURER WITHIN THREE (3) DAYS OF RELEASE TO WORK WITH A COPY TO THE EMPLOYEE AND HIS OR HER ATTORNEY***

***DWC/MAB #: _____*** ***INSURER'S #:_____***

***EMPLOYEE INFORMATION:***

Social security # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____ DOB _____

***EMPLOYER INFORMATION:***

FEIN # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

***INSURANCE CARRIER:***

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

Injury Date _____

***ADJUSTING COMPANY:***

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION. SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM.

**This medical report is rendered pursuant to Section 28-33-8 of the Rhode Island Workers' Compensation Act.**

This is to certify that the above named employee is able to return to work on _____, as follows:

Check one: ☐ A. Regular duty, no restrictions ☐ B. Modified duty, limitations as follow:

***Please check the appropriate box(s):***

- ☐ No operating heavy machinery or vehicles
- ☐ No repetitive climbing ladders or stairs
- ☐ May lift up to _____ pounds only
- ☐ No reaching above shoulders
- ☐ No repetitive twisting, bending, squatting
- ☐ No repetitive stooping, kneeling
- ☐ Alternate standing/sitting
- ☐ No work involving uses of right/left _____
- ☐ Sit down work only
- ☐ Keep wound clean and dry
- ☐ Other _____

***This certification is based on medical examination performed on _____.***

Physician's Signature_____ Date _____

Physician's Name _____ Treatment Facility _____

Physician's Assistant Signature _____

Supervising Physician's Name _____

Physician's Address _____